Report to the Legislature
to Advance Health Care Payment Reform in Maine

Background

LD1444 charged the Advisory Council on Health Systems Development to solicit input and develop recommendations on payment reform in Maine. Specifically, the Council was instructed to:

- Solicit input from various stakeholders, including private purchasers of health care, working on the measurement and reporting of health care value;
- Consult with state agencies with expertise in provider reimbursement and payment systems;
- Integrate any reforms adopted by the United States Congress or federal agencies that affect provider reimbursement;
- Review and consider payment reform proposals in other states; and
- To the extent permitted by federal and state law, recommend unified payments systems across public and private sectors.

The Council educated itself about payment reform through a *Primer* developed by the Governor's Office of Health Policy and Finance and held three public educational sessions, one co-sponsored with the Maine Health Management Coalition. The Council heard from national experts, other state leaders and the federal government as well as from private and public sector leaders in Maine. In fulfilling its charge, the Council has found unprecedented agreement among policymakers, payers, purchasers, providers and consumers that fundamental reform is needed to support safe, effective and efficient patient-centered care. A growing consensus concludes that how we pay for health care contributes to rising costs and our failure to improve outcomes. Our traditional fee-for-service approach to payment creates financial incentives to provide more costly services but does not provide adequate incentives to improve the efficiency and quality of care and keep people healthy. As commonly noted, preventive and primary care is not well funded while inefficiencies and inappropriate care contribute to avoidable costs. In other words, the payment structure rewards volume not value. Redirecting how we pay for care is believed to have great promise in improving care and reducing costs but requires significant redirection of the status quo. While several states have established commissions to design unified payment systems, no state has yet implemented its reforms nor has a single best payment reform model emerged.

Our work also has been informed by bills currently under deliberation in Congress. Federal reform holds the promise of waivers and demonstrations that will bring Medicare into state reform efforts. Other federal reforms also are likely to reduce barriers and lead to more

opportunities for Maine. Included in proposals still under consideration are requirements for U.S. DHHS to develop bundled payments for acute and post acute care; establish pilot programs, including accountable care organizations and patient centered medical homes, with participation by both Medicare and Medicaid. These initiatives, if enacted, are generally scheduled to become effective in 2011 and beyond. The Council strongly believes that Maine cannot wait for federal reform to build capacity and advance beyond traditional fee-for-service payment that increases costs without providing value. Higher costs also mean that more people go uninsured and, those that are insured, must allocate higher portions of their incomes to pay for premiums. Moving forward now will assure readiness for any federal reforms that are enacted and stem the tide of cost at the expense of value.

Status of Payment Reform in Maine

Early and important steps have been taken in Maine to better understand and address components of payment reform.

- A cost driver report conducted by the Dirigo Health Agency's Maine Quality Forum shows where our health care dollar is spent, how spending often goes for care that is potentially avoidable, and where resources can be shifted for better outcomes and lower cost growth. This report provides a useful baseline for measuring the impact of future payment reform efforts in re-aligning services and costs to more effective use.
- Governor Baldacci became an early supporter of patient-centered medical homes as one way to restore and financially recognize the essential role of primary care in our state's health care system and, with the Legislature, provided funds to support MaineCare's participation in a statewide medical home pilot program.
- Maine's HealthInfoNET creates a statewide electronic health information exchange connecting providers with timely clinical data for decision making. The electronic transmission of timely data across providers and settings can reduce costs by avoiding errors and eliminating duplication of tests. Health information technology also is central to the collaboration needed to implement payment systems that bundle reimbursement for services across providers.
- The Maine Health Management Coalition is working with purchasers, payers and providers to identify potential payment reform models that include Medicaid and state employees. Part of their work includes the identification of state policy and regulatory barriers to implementation.
- Individual providers, such as Martin's Point, are exploring opportunities for global payment models that would require the organization to manage access, cost, and quality of patient care within a predefined dollar amount.

- The State Health Plan, in its capacity to guide the certificate of need process, has facilitated movement to greater "systemness" across the state. The legacy of fee-for-service was the creation of a fragmented system where each provider gets paid for components of care without accountability for the total outcome or cost. Most payment reforms require the creation of rational systems of care able to administer and manage payment methods that hold entities accountable for the quality and cost of a broader array of services. Over the past five years, Maine has seen significant re-alignment of solo practices into group practices and the creation of integrated delivery systems where hospitals and physicians come under a single organizational structure. These entities will join others as natural candidates for embracing payment reform in Maine. As we move forward with payment reform, however, we must consider how best to protect and preserve access to care in areas dominated by practices and hospitals unaffiliated with larger health care systems.

Payers and providers have taken the leadership in moving payment reform in Maine. Voluntary efforts to date lay important groundwork for reform and underscore the importance of local momentum and leadership in bringing about change. This is especially true given that currently there is no consensus on the best model(s) of payment reform and that trial and error of small scale pilots will be critical to identifying an effective and feasible solution(s) for Maine.

Major Conclusions

Four major conclusions from our deliberations have shaped our recommendations to the Legislature.

1. Despite considerable activity in payment reform at the community level in Maine, there is no unifying vision for directing our efforts. We are mindful that our charge from the Legislature is to design a "unified payment system". This requires that we have clearly defined principles that can govern our actions, coordinate our efforts, and map our progress over time.

2. It is not clear at this point what the best model(s) of payment reform should be in Maine. Local community momentum and leadership are likely to be the springboard for payment reform in Maine. A combination of one or more of the following strategies will likely be needed given the diversity of Maine's delivery system and needs.

   Accountable Care Organizations (ACO's) or groups of providers who come together in a formal or contractual manner to accept responsibility for the quality and cost of health care services provided to a defined set of patients.

   - Episode of care payment systems (bundled payments) made to a group of providers to cover all of the services a particular patient requires during a defined episode of illness.
   - Global payment systems which are prospectively paid, fixed dollar amount payments for a specified range of services provided to patients over a set period of time.

- Payments for coordinating the care of patients with complex or chronic conditions to prevent complications of disease and reduce costs by reducing the need for costly interventions related to those complications.
- Incentives for health care providers that achieve target levels of performance.

3. State government has a legitimate and essential role to play in supporting and shaping payment reform building on community-based experimentation. First, government articulates and protects the public's interest when weighing the merits of potential policy or statutory changes proposed by payment reform sponsors. Second, government facilitates the inclusion of public purchasers in payment reform efforts. Third, government can act proactively in advancing reform as needed through participation in national demonstrations, applications for federal waivers, and establishing a regulatory environment aligned with core principles and federal reforms. Finally, government monitors payment reform efforts so that good experiments can be identified and expanded and those not serving the public's interest discontinued.

Recommendations

These recommendations recognize that payment reform is a work in progress and that it is premature to make recommendations regarding any one model or approach. Rather, we propose a process to assure progress is made and measured.

1. The Legislature adopt the following set of core principles to guide payment reform efforts toward a common vision. Specifically, core principles will be used to (a) determine whether and what policy and regulatory changes are needed to achieve our payment reform goals; (b) evaluate the merits of proposed payment reform strategies requiring state support for implementation; (c) assess our progress in fulfilling our vision over time; and (d) determine additional actions that should be taken by state government to meet payment reform objectives. While no one payment reform strategy will fulfill all principles, collectively our efforts should:

   A. Support integrated, efficient and effective systems of care delivery and payment.
   - Clear points of accountability for clinical and financial management.
   - Payment arrangements that encourage more affordable and effective care options.
   - Reduction in the growth of health care costs with savings and risks shared by providers, payers, purchasers and patients.
   - Improved communication and coordination that reduce redundancy.

   B. Promote a patient-centered approach to service payment and delivery.
   - Improve the effectiveness and efficiency of care from a consumer perspective.
   - Promote shared decision making where appropriate among patients and clinicians that recognizes patient values and preferences.

- Incorporate linguistic and cultural awareness.
- Reward successful patient outcomes.
- Measure and promote consumer satisfaction.

C. Encourage and reward the prevention and management of disease.

- Rebalance payments to promote primary and preventive care.
- Recruit and support an adequate network of primary care.
- Create collaborative approaches that foster self management, the appropriate use of community resources, and communication across clinicians, consultants, institutional providers and settings.
- Incent efficient and effective delivery systems and outcomes.

D. Promote the value of care over volume to measurably lower costs

- Encourage the use of evidence to guide clinical decision making.
- Incent providers for meeting individual patient needs and effectively managing resources.
- Discourage ineffective and inappropriate care and eliminate waste.
- Encourage patients and providers to select high quality care systems at the best price, and use clinicians and settings that deliver better, more comprehensive quality care more affordably.
- Assure savings are shared with consumers and payors through lower costs.

E. Support payments and processes that are transparent, easy to understand, and simple to administer for patients, providers, purchasers and other stakeholders.

- Disclose the structure of provider payment arrangements.
- Identify provider incentives.
- Report impact on quality of care, costs, satisfaction.
- Provide understandable information to consumers about service pricing.
- Use data to support accountability to those within and outside the delivery system.

F. Balance the interests of patients, providers and payors while pursuing necessary change.

- Assure access to participant safety net providers.
- Provide choice of providers in urban and rural areas where quality and cost considerations allow.
- Support policies that adjust for treating adverse conditions or complex patients.
- Avoid cost shifting within and outside provider networks and between payors.
- Recognize that payment reform requires change and shared responsibility to achieve its goals.

2. The Legislature encourage multiple community-based pilots of payment reform that will enable us to learn, in a controlled environment, about models that work for both patients and providers and which, alone or in combination, move us toward achieving our core principles.

3. The Legislature authorize the Advisory Council on Health Systems Development and its expanded Payment Reform Sub-Committee, with representatives from the Bureau of Insurance (BOI) and the Attorney General's Office as technical consultants, to work collaboratively with sponsors of proposed payment reform models to:
   - Consider emerging research for its implications for payment reform in Maine
   - Assess the merits of the proposed models against the core principles
   - Minimize any potential for cost shifting from demonstrations to non-participants in the demonstrations
   - Identify regulatory waivers for consideration by the Bureau of Insurance to advance payment models for a three-year demonstration period and the conditions under which they will be monitored and findings reported back to the Legislature at least annually.
   - Recommend to the Legislature no later than January 2011 any legislative or regulatory reforms needed to advance models
   - Develop an approach for building consumer awareness about payment reform in Maine

   Nothing in this recommendation precludes payment reform strategies, not requiring government action and in compliance with existing requirements, from proceeding under terms established by their sponsors.

4. The Legislature authorize a pilot that includes Medicaid and Medicare and that the Council serve as a liaison with Maine DHHS and U.S. DHHS in its design. The pilot will identify:
   - Measurable goals consistent with the core principles
   - Methods for monitoring goals and reporting findings to the Legislature
   - The identification of state policy and/or statutes needed to advance the goals of the pilot
   - An evaluation of program effectiveness and impact on cost, quality, access and core principles.

   Nothing in this recommendation precludes MaineCare from continuing and expanding its efforts to improve value in the MaineCare program through utilization review, care management and managed care strategies. Those strategies may have features in common with payment reform and the Department should coordinate them closely with the Council's efforts.

5. The Legislature examine the Hospital and Medical Care Provider Cooperation Act to assure adequate protections exist to foster the collaboration needed to support payment reform models.

6. The Legislature request the Council to report every six months to the Joint Committee on Insurance and Financial Services its findings with respect to progress in implementing payment reform and recommendations for further action to stimulate and facilitate implementation of the core principles and if community models have not been implemented by January 2011, to make recommendations for state action. The report should assess the impact of demonstrations and pilots with respect to the core principles, access, costs and outcomes and recommendations for any permanent changes to state policy and/or statute to advance reform.

Members of the Advisory Council on Health Systems Development and its Payment Reform Sub-Committee

Arthur Blank	Bar Harbor
Sen. Peter Bowman	Kittery
Nona Boyink♦	Mt. Vernon
David Brenerman♦	Portland
John Carr♦	York
Andrew Coburn, PhD	Yarmouth
Josh Cutler, MD♦	Portland
Gail Dana-Sacco, PhD, MPH	Hampden
Robert Downs♦	Pittsfield
Maroulla Gleaton, MD	Palermo
Anne Graham, MSN, RN, PNP♦	North Yarmouth
Lani Graham, MD**	Portland
James Highland, PhD., MHSA♦	Portland
Edward Miller	Hallowell
Dora Mills, MD, MHP	Brunswick
Sen. Peter Mills♦	Skowhegan
Rep. Anne Perry	Calais
Rep. Charles Priest♦	Brunswick
Rep. Wesley Richardson	Warren
Brian Rines, PhD *♦	So. Gardiner

*Chair

**Vice Chair

♦ Payment Reform Sub-Committee member